CONSENT FOR INFORMATION DISCLOSURE

I, _____, hereby authorize the exchange of information between _____and the SD DEPARTMENT OF HUMAN SERVICES, DIVISION OF ALCOHOL AND DRUG ABUSE, and the **re-disclosure** of that information by _____and the SD Division of Alcohol and Drug Abuse to:

____ South Dakota Department of Social Services for Medicaid information
____ South Dakota Department of Health
____ South Dakota Department of Corrections or Juvenile Corrections Agent, _____
____ Unified Judicial System or Court Services Officer, _____
____ My parents and/or legal guardian and/or prospective foster parents_____
____ Mountain Plains Research for purpose of reporting required demographic information
____ Law Enforcement Officials (City and/or County)
____ My current and/or former educational institution for purpose of obtaining academic information
____ The designated accredited alcohol and drug treatment provider and/or funding source necessary to facilitate my entry into chemical dependency treatment or services.
____ Physician and/or Medical Clinic, _____
____ Other _____
____ Other _____

Purpose of and need for the disclosure is to inform the person(s) or agency(ies) listed above of my:

_____ Treatment Needs Assessment
_____ Diagnosis and Treatment Recommendations
_____ Eligibility for treatment services
_____ Financial Information and Funding Sources
_____ Medical, dental, and/or eye care information and/or eligibility
_____ Treatment Plan and/or Continued Care Reviews
_____ Attendance, cooperation, and progress in treatment
_____ Discharge Summary and/or Aftercare Plans
_____ Group data for reports to evaluate outcome of treatment
_____ Education Information
_____ Legal Information
_____ other (be specific): _____

The above information will be used for the following: To provide the above noted individuals with information requested as noted above, about the individual named above, to coordinate all available information to ensure placement in the appropriate level of care, to ensure adequate funding, determine the diagnosis, course of treatment, follow-up, or need for other services, to ensure a full continuum of care and to ensure quality services.

I understand that *some or all of this information may at times be communicated via electronic transmission.*

I also understand that I may revoke this consent in writing at any time, except to the extent that action has been taken in reliance on it, by signing the revocation section of my copy of this form and returning it to _____at _____. In any event, this consent will expire:

One year after this consent form is signed.

I also understand that my alcohol and/or treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F. R. Pts. 160 & 164, and 42 U.S.C. §§ 290 dd-2 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that recipients of this information may redisclose it only in connection with their official duties.

Dated: _____ **Client Signature:** _____

Witness Signature: _____

REVOCATION SECTION I hereby revoke this consent

_____ _____

(Signature) (Date)